Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Adenoma in the Small Bowel

TO THE EDITOR: The case report in the July issue describing carcinoma arising in Crohn disease [Burbige EJ, Bedine MS, Handelsman JC: Adenoma of the small intestine in Crohn disease involving the small bowel] is interesting. However, to add to the value and legitimacy of the case, before it becomes entrenched in the folklore of regional enteritis, documentation of the neoplastic changes would be worthwhile.

The photograph submitted is unconvincing, in my opinion. No pathologist is listed in the case report to lend credibility to the diagnosis. These flaws combine to allow skepticism about an otherwise nice case study.

DAVID A. MULKEY, MD
Associate Pathologist
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Dr. Burbige Replies

TO THE EDITOR: I wish to thank Dr. Mulkey for his comments and commend him for his concern and vigilance.

Unfortunately, it is not always possible to include detailed pathologic material in a simple case report. The case was reviewed by at least two pathologists at The Johns Hopkins Hospital. I will be happy to obtain a slide and forward it to Dr. Mulkey for his review.

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Multiply Injured Patients

TO THE EDITOR: It was with interest that I read the Trauma Rounds' article "Initial Evaluation and Treatment of Multiply Injured Patients" in the May issue. I have become accustomed to reading and learning from Trauma Rounds and appreciate the efforts of Drs. Trunkey and Blaisdell and their staffs in preparing this series. I would like to comment on several aspects of this recent article.

The article described a patient with obvious head, facial and chest, and possible abdominal, injuries who was both hypotensive and tachycardic. It quite appropriately focused on the ABC's of initial management; however, I was bothered by the impression the article gave relative to the management of the airway by orotracheal intubation. I realize a lengthy discussion of decisions that go into the airway management of an acutely injured patient was beyond the scope of this article. but the danger of permanent cervical spinal cord injury while orotracheally intubating a patient with an unstable cervical spine fracture cannot be overstated. I feel strongly that until it can be definitively ascertained by radiographs, patients with evidence of head or facial injuries should be assumed to have a cervical spine fracture and their airway managed by nasotracheal intubation, cricothyroidotomy or Ambu bag and mask. This possibly fatal mistake is too important to be omitted from an article on the management of traumatized patients.

I couldn't agree more that an unstable patient with evidence of thoracic injury should undergo closed tube thoracostomy prior to x-ray.

As to the emergency management of patients in hypovolemic shock secondary to abdominal injury, I would like to relate that our experience with the use of Medical Anti-Shock Trousers (MAST) can be characterized as nothing but